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Vol. M95 Page 25698TYPE OR
PRINT IN
PERMANENT
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ID. TAG NO.46.3
Local File NumberOREGON DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION
CENTER FOR HEALTH STATISTICS 136
CERTIFICATE OF DEATH

State File Number

DECEDENT

PARENTS

DISPOSITION

REGISTRAR

CERTIFIER

CAUSE OF DEATH

1. DECEDENT'S NAME First <u>Bertha</u> Middle <u>Roxie</u> Last <u>IVIE</u>		2. SEX <u>Female</u>	3. DATE OF DEATH (Month, Day, Year) <u>September 16, 1995</u>
4. SOCIAL SECURITY NUMBER <u>525-48-3872</u>	5a. AGE Last Birthday (Years) <u>83</u>	5b. Under 1 Year Mos. Days Hours Mins.	5c. Under 1 Day Mins.
6. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		8. BIRTHPLACE (City and State or Foreign Country) <u>Nashoba, Oklahoma</u>	
7. DATE OF BIRTH (Month, Day, Year) <u>June 10, 1912</u>		9a. PLACE OF DEATH (Check only one) <input type="checkbox"/> Hospital <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other <input checked="" type="checkbox"/> Decedent's Home <input type="checkbox"/> Other (Specify)	
9b. FACILITY NAME (If not institution, give street and number) <u>Route 5 Box 1075</u>		9c. CITY, TOWN, OR LOCATION OF DEATH <u>Klamath Falls</u>	
10a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <u>LP Nurse</u>		10b. KIND OF BUSINESS/INDUSTRY <u>Medical</u>	
11. MARITAL STATUS: <u>Widowed</u> Never Married, Widowed, Divorced (Specify)		12. SPOUSE (If Married, Widowed) <u>Joseph Ivie</u>	
13a. RESIDENCE - STATE <u>Oregon</u>	13b. COUNTY <u>Klamath</u>	13c. CITY, TOWN OR LOCATION <u>Klamath Falls</u>	13d. STREET AND NUMBER <u>Route 5 Box 0175 A</u>
13e. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	13f. ZIP CODE <u>97601</u>	14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	15. RACE American Indian, Black, White, etc. (Specify) <u>White</u>
16. DECEDENT'S EDUCATION (Specify only highest grade completed) <u>Elementary/Secondary (0-12)</u>		17. College (14 or 5+) <u>2</u>	
17. FATHER - NAME first middle last <u>James - Perry</u>		18. MOTHER - NAME first middle maiden <u>Ellen - Edwards</u>	
19. INFORMANT - NAME and relationship to deceased <u>Bertha Ivie - Self</u>		20. LOCATION - City or Town, State <u>Klamath Falls, Oregon</u>	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <u>Eternal Hills Memorial gardens</u>	
21c. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACQUIRING TUCH <u>Edith A. A. A.</u>		21d. LICENSE NUMBER (Of Licensee) <u>3588</u>	
22. NAME, ADDRESS AND ZIP OF FACILITY <u>Eternal Hills Funeral Home</u>		23. DATE FILED (Month, Day, Year) <u>SEP 20 1995</u>	
24. REGISTRAR'S SIGNATURE <u>Janet Bailey Guber</u>		25. DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> N/A	
26. WAS GIFT MADE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> N/A		27. TIME OF DEATH <u>4:45P M</u>	
28. WAS MEDICAL EXAMINER NOTIFIED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		29. To the best of my knowledge, death occurred at the time, date, place and due to the cause(s) and manner stated. (Signature) <u>Kenneth K. Magee M.D.</u>	
30. DATE SIGNED (Month, Day, Year) <u>9-18-95</u>		31. DATE SIGNED (Month, Day, Year) <u>9-18-95</u>	
32. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print) <u>Kenneth K. Magee M.D. 1900 Main Street Klamath Falls, Oregon 97601</u>		33. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)	
34. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c). Do not enter mode of dying, e.g. Cardiac or Respiratory Arrest) PART I (a) <u>Carcinoma of Cervix with metastases</u> DUE TO, OR AS A CONSEQUENCE OF: (b) DUE TO, OR AS A CONSEQUENCE OF: (c) PART II OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not resulting in the underlying cause given in PART I.		Interval between onset and death <u>1 1/2 years</u> Interval between onset and death Interval between onset and death 37. Did tobacco use contribute to the death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 38. AUTOPSY <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 39. If YES, were findings considered in determining cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
40. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Undetermined Manner <input type="checkbox"/> Suicide <input type="checkbox"/> Legal Intervention <input type="checkbox"/> Homicide		41a. DATE OF INJURY (Month, Day, Year) 41b. TIME OF INJURY 41c. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
41d. PLACE OF INJURY - At home, farm, street, factory, office, building etc. (Specify) 41e. LOCATION (Street and Number or Rural Route Number, City or Town, State)		42. DESCRIBE HOW INJURY OCCURRED 43. DATE SIGNED (Month, Day, Year) 44. COUNTY	

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ORIGINAL-VITAL STATISTICS COPY

DATE ISSUED: SEP 20 1995Janet Bailey Guber
JANET BAILEY GOBER
COUNTY REGISTRAR
KLAMATH COUNTY, OREGON

STATE OF OREGON: COUNTY OF KLAMATH: ss.

Filed for record at request of _____ the _____ 22nd day
of Sept A.D., 19 95 at 1:48 o'clock P M., and duly recorded in Vol. M95
of Deeds on Page 25698

FEE \$10.00

5805 Delaware St
K Falls Or 97603By Bernetha G. Jetch, County Clerk